



SOUTH DAKOTA BOARD OF NURSING

SOUTH DAKOTA DEPARTMENT OF HEALTH

4305 S. Louise Avenue Suite 201 □ Sioux Falls, SD 57106-3115

(605) 362-2760 □ FAX: 362-2768 □ www.state.sd.us/doh/nursing

ADDENDUM to Approved Collaborative Agreement

I understand and acknowledge that amendments to the practice act effecting the collaborative agreement take precedence and will modify the terms of a previously approved collaborative agreement on file with the Joint Board of Nursing and Medical and Osteopathic Examiners.

I further understand recent changes in the practice act:

Administrative Rules South Dakota 20:62:03:03. Collaboration with a licensed physician or physicians. A nurse practitioner or nurse midwife may perform the overlapping scope of advanced practice nursing and medical functions defined in SDCL 36-9A-12 and 36-9A-13, in collaboration with a physician or physicians licensed under SDCL chapter 36-4. Collaboration by direct personal contact with each collaborating physician must occur no less than twice each month unless it is established in the collaborative agreement that one of the twice monthly meetings may be held by telecommunication. Collaboration with each collaborating physician shall occur at least once per month by direct personal contact.

Administrative Rules South Dakota 20:62:03:05. Collaboration – Separate practice location. In addition to the required two meetings per month, the collaborating physician must be physically present on-site every ninety days at each practice location. This requirement does not apply to locations where health care services are not routine to the setting, such as patient homes and school health screening events.

I, the undersigned, hereby acknowledge and affirm these new rules and accept them as an addendum to my previously approved collaborative agreement.

Primary Collaborating Physician:

| | | | |
|-----------------------------|--------------------|--------------------|---------------|
| _____ Print or Type Name | _____ Signature | _____ License # | _____ Date |
|-----------------------------|--------------------|--------------------|---------------|

CNM or CNP:

| | | | |
|-----------------------------|--------------------|--------------------|---------------|
| _____ Print or Type Name | _____ Signature | _____ License # | _____ Date |
|-----------------------------|--------------------|--------------------|---------------|

Mail original form with signatures to the South Dakota Board of Nursing:
4305 S. Louise Avenue, Suite 201; Sioux Falls, South Dakota 57106-3115.

Retain a copy for your records.